EXHIBIT
Menna 1
DATE 3/29/18 RPTR GT
DALCO REPORTING

(PLEASE PRINT OR TYPE) #0503 HIP

Your Last Name	First Name	Middle Name	Sex ☐ M ☐ F	Date of Birth Mo. / Day / Year
MENNA	Leonard	J		[redacted]

Address [redacted] Zip Code 11414

Social Security # [redacted] Home Telephone # [redacted]

Name of Employer: Eisner Ashes — Date Employed: 11/8/07

Full Name of Beneficiary (Example Mary Doe Mr. and Mrs. John Doe): Carol Menna — Relationship: Mother

Are you covered by any other Health Insurance? ☐ Yes ☑ No — Carrier

If dependent coverage is provided, do you have eligible dependents? Yes ☐ No ☑

List below all family members to be covered. Name. Indicate different last name if applicable			Birth Date MO DAY YR	Relationship
		SS#	/ /	☐ Husband ☐ Wife
SPOUSE'S NAME	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter

ENTERED

I hereby apply for that coverage for which I am or may become eligible under the group policy or policies issued by L I F E Benefit Plan. I authorize such deductions, if any, from my earnings as may be required as my contribution to the cost of such coverage. I designate the above as my beneficiary under any life insurance issued and certify that the above is my correct date of birth. I have read this or it has been explained to me and I am signing on the reverse side.

HIP

S- 01/08

LIFE

League of International Federated Employees
325-73rd STREET • BROOKLYN, N.Y. 11209 • (718) 238-2399

APPLICATION AND CHECK-OFF AUTHORIZATION BLANK

I, the undersigned, hereby apply for membership in the above Union and I authorize it to represent me for the purpose of collective bargaining, and I authorize and irrevocably direct my Employer to deduct from my wages initiation fees and dues uniformly required by said Union as a condition of acquiring or maintaining membership, and in compliance with the National Labor Relations Act of 1974. The amount deducted each month shall be forwarded to the Secretary-Treasurer of said Union.

This authorization may be revoked by me as of any anniversary date hereof, by written notice of such revocation signed by me and given to my Employer and the Union by certified mail, not less than thirty (30) days nor more than sixty (60) days before any such anniversary date, or on the termination date of the Collective Bargaining Agreement covering my employment, by like notice prior to such termination date, whichever occurs sooner.

"Contributions of gifts to L I F E are not tax deductible as charitable contributions However, they may be tax deductible as ordinary and necessary business expenses."

Signature [signature] Date 12/2/07

(Please Answer All Questions In Ink)

ALL REPLIES WILL BE KEPT STRICTLY CONFIDENTIAL (OVER)

EXHIBIT
Acevedo 01
DATE 3/25/18 RPTR GT
DALCO REPORTING

(PLEASE PRINT OR TYPE) #0509 HIP

Your Last Name	First Name	Middle Name	Sex	Date of Birth Mo. Day Year
MENNA	Leonard	T	☑ M ☐ F	[redacted]

[redacted] Zip Code 10471

Name of Employer: Liberty Ashes — Date Employed: 11/8/07

Full Name of Beneficiary (Example Mary Doe Mr. and Mrs. John Doe): Carol Menna — Relationship: Mother

Are you covered by any other Health Insurance? ☐ Yes ☑ No — Carrier

If dependent coverage is provided, do you have eligible dependents? Yes ☐ No ☑

List below all family members to be covered. Name (indicate different last name if applicable)			SS#	Birth Date MO DAY YR	Relationship
				/ /	☐ Husband ☐ Wife
SPOUSE'S NAME	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter

ENTERED

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HIP

S- 01/08

LIFE

League of International Federated Employees

325-73rd STREET • BROOKLYN, N.Y. 11209 • (718) 238-2399

APPLICATION AND CHECK-OFF AUTHORIZATION BLANK

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This authorization may be revoked by me as of any anniversary date hereof, by written notice of such revocation signed by me and given to my Employer and the Union by certified mail, not less than thirty (30) days nor more than sixty (60) days before any such anniversary date, or on the termination date of the Collective Bargaining Agreement covering my employment, by like notice prior to such termination date, whichever occurs sooner.

"Contributions of gifts to L I F E are not tax deductible as charitable contributions. However, they may be tax deductible as ordinary and necessary business expenses."

Signature ..... Date 12/11/07

(Please Answer All Questions In Ink)

ALL REPLIES WILL BE KEPT STRICTLY CONFIDENTIAL (OVER)

EXHIBIT
Acevedo2
DATE 3/29/18 RPTR GT
DALCO REPORTING

(PLEASE PRINT OR TYPE)

Your Last Name	First Name	Middle Name	Sex	Date of Birth Mo. Day Year
ACevedo	Luis		☒ M ☐ F	[redacted]

Address	City	State	Zip Code
[redacted]		NY	11417

Social Security #	Home Telephone #
[redacted]	[redacted]

Name of Employer: LIBERTY ASHES Inc. Date Employed: 3/17/10

Full Name of Beneficiary Example: Mary Doe Mr. and Mrs. John Doe: CARMEN ACevedo Relationship: WIFE

Are you covered by any other Health Insurance? Yes No Carrier

If dependent coverage is provided, do you have eligible dependents? Yes No

List below all family members to be covered. Name (Indicate different last name if applicable)			SS#	Birth Date MO DAY YR	Relationship
				/ /	☐ Husband ☐ Wife
SPOUSE'S NAME	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter

I hereby apply for coverage to which I do or may become eligible under the group policy or policies issued by L.I.F.E. Benefit Plan. I authorize such deductions from any earnings as may be required as my contribution to the cost of such coverage. I designate the above as my beneficiary under [illegible] insurance issued, and certify that the above is my correct name. I have read this card as been explained to me and I am signing on the reverse side.

LIFE

League of International Federated Employees

325 [illegible] STREET • BROOKLYN, N.Y. 11209 • (718) 238-2399

APPLICATION AND CHECK-OFF AUTHORIZATION BLANK

I, the undersigned, hereby apply for membership in the above Union and I authorize it to represent me for the purpose of collective bargaining, and I authorize and irrevocably direct my Employer to deduct from my wages the initiation fee, and dues uniformly required by said Union as a condition of acquiring or maintaining membership, and in compliance with the National Labor Relations Act of 1974. The amount deducted each month shall be forwarded to the Secretary-Treasurer of said Union.

This authorization may be revoked by me as of any anniversary date hereof, by written notice of such revocation given by me personally to my Employer and the Union by certified mail, not less than thirty (30) days nor more than sixty (60) days before any such anniversary date, or on the termination date of the Collective Bargaining Agreement covering my employment, by like notice prior to such termination date, whichever is earlier.

Contributions of gifts to L.I.F.E. are not tax deductible as charitable contributions. However they may be tax deductible as ordinary and necessary business expenses.

Signature: [signature] 6/17/10

(Please Answer All Questions in Ink)

ALL REPLIES WILL BE KEPT STRICTLY CONFIDENTIAL (OVER)

EXHIBIT 3
ACevedo
DATE 3/29/18 RPTR GT
DALCO REPORTING

(PLEASE PRINT OR TYPE)

Your Last Name	First Name	Middle Name	Sex	Date of Birth
ACevedo	Luis		☒ M ☐ F	[redacted]

Address [redacted] City [redacted] State NY Zip Code 11417

Soc. Sec. # [redacted] Home Telephone # (347) 405 4012

Name of Employer: Liberty Ashes Inc. Date Employed: 3/17/10

Full Name of Beneficiary (Example Mary Doe Mr. and Mrs. John Doe): Christine ACevedo Relationship: Wife

Are you covered by any other Health Insurance? Yes No ☒ Carrier

If dependent coverage is provided, do you have eligible dependents? Yes No ☒

List below all family members to be covered. Indicate different last name if applicable			SS#	Birth Date MO DAY YR	Relationship
				/ /	☐ Husband ☐ Wife
SPOUSE'S NAME	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST		/ /	☐ Son ☐ Daughter

I hereby apply for [illegible] coverage for which I or my dependents may become eligible under the group policy or policies issued by L.I.F.E. Benefit Plan. I authorize such deductions from any earnings as may be required as my contribution to the cost of such coverage. I designate the above as my beneficiary under [illegible] insurance issued, and certify that the above is my correct date of birth. I have read this and it has been explained to me and I am signing on the reverse side.

LIFE

League of International Federated Employees

325 73rd STREET • BROOKLYN, N.Y. 11209 • (718) 238-2399

APPLICATION AND CHECK-OFF AUTHORIZATION BLANK

I, the undersigned, hereby apply for membership in the above Union and I authorize it to represent me for the purpose of collective bargaining, and I authorize and irrevocably direct my Employer to deduct from my wages the initiation fee and dues uniformly required by said Union as a condition of acquiring or maintaining membership, and in accordance with the National Labor Relations Act of 1974. The amount due and owing each month shall be forwarded to the Secretary-Treasurer of said Union.

This authorization may be revoked by me as of any anniversary date hereof, by written notice of such revocation served by me and given to my Employer and the Union by certified mail, not less than thirty (30) days nor more than sixty (60) days before any such anniversary date, or on the termination date of the Collective Bargaining Agreement covering my employment, by like notice prior to such termination date, whichever occurs sooner.

Contributions or gifts to L.I.F.E. are not tax deductible as charitable contributions. However, they may be tax deductible as ordinary and necessary business expenses.

Signature [signature] Date 6/17/10

(Please Answer All Questions in Ink)

ALL REPLIES WILL BE KEPT STRICTLY CONFIDENTIAL (OVER)

EXHIBIT 1
Powell
DATE 3/29/18 RPTR GT
DALCO REPORTING

LBP → 6/15

LIFE

JUN 19 2015

League of International Federated Employees
325 73rd STREET • BROOKLYN, N.Y. 11209 • (718) 238-2399

Stuffle as per Francesco

APPLICATION AND CHECK-OFF AUTHORIZATION BLANK

I, the undersigned hereby apply for membership in the above Union and authorize it to represent me for the purposes of collective bargaining, and I authorize and irrevocably direct my Employer to deduct from my wages initiation fees and dues uniformly required by said Union as a condition of acquiring or maintaining membership, and in compliance with the National Labor Relations Act of 1974. The amount deducted each month shall be forwarded to the Secretary-Treasurer of said Union.

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"Contributions or gifts to L.I.F.E. are not tax deductible as charitable contributions. However, they may be tax deductible as primary and necessary business expenses."

Signature Quamaine Powell Date 6-19-2015

(Please Answer All Questions In Ink)

ALL REPLIES WILL BE KEPT STRICTLY CONFIDENTIAL (OVER)

(PLEASE PRINT OR TYPE) #0506 #0502

Your Last Name	First Name	Middle Name	Sex	Date of Birth
Powell	Quamaine	Jr.	☒ M ☐ F	[redacted]

[redacted] State NY Zip Code 11570

Home Telephone # [redacted]

Name of Employer: Liberty Ashis Inc. Date Employed

Full Name of Beneficiary (Example Mary Doe Mr. and Mrs. John Doe) Relationship

Are you covered by any other Health Insurance? ☐ Yes ☒ No If Yes: Carrier

If dependent coverage is provided, do you have eligible dependents? Yes ☒ No ☐

List below all family members to be covered

	Name (indicate date of marriage if applicable)		Birth Date MO DAY YR	Relationship
		SS#	/ /	☐ Husband ☐ Wife
SPOUSE'S NAME	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different) Powell II	FIRST Quamaine	6/25/15	☒ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter

ENTERED JUN 19 2015

I hereby apply for that coverage for which I am or may become eligible under the group policy or policies issued by L.I.F.E. Benefit Plan. I authorize such deductions, if any, from my earnings as may be required as my contribution to the cost of such coverage. I designate the above as my beneficiary under any life insurance issued and certify that the above is my correct date of birth. I have read this or it has been explained to me and I am signing on the reverse side.